

When to Include the Family

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There is always a dynamic interplay among the family, patient and the illness. Hardly a patient who is in close contact with others experiences disease alone and without influence.

Doherty and Baird (1983): Three levels of family care:

1. Generally see patient alone for minor acute or self-limiting problems
2. Family meeting desirable for:
 - a) treatment failure for recurrence of symptoms
 - b) routine prevention/educational care (ie. prenatal, routine peds)
3. Family conference essential for:
 - a) chronic illness
 - b) serious acute illness
 - c) psychosocial problems
 - d) problems requiring lifestyle change (e.g. obesity)
 - e) death

Why include the family?

To help the physician:

Family can provide information about the patient and history

Family can provide support for patient adherence to treatment plans

To help the patient:

Family can provide support for patient adhering to medical plans

Family can help patient understand a diagnosis and requirements of treatment

Family can help patient ask relevant questions

To help the family:

Family can cope better with diagnosis when they understand and can ask questions directly of provider

Family can feel like a part of the solution (some evidence that adolescent fathers who participate in pre-natal care are more likely to stick around after birth)

Specific situations in which to think about/offer including family (broadly defined):

Prenatal and well-child care

Chronic disease requiring lifestyle/behavior change

New diagnosis of life-threatening disease

Important change in health status

Variables that influence inclusion of family include: age, marital status/living situation, culture, independence/privateness of patient.

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The Biopsychosocial Assessment of the Family

CHAPTER 1

Basic Premises of Family-Oriented Primary Care

Utilizing the Family as a Resource

There is a tendency for all living things to join up, establish linkages, live inside each other, return to earlier arrangements, get along whenever possible. This is the way of the world.

LEWIS THOMAS
The Lives of a Cell (1)

Who Is the "Family" in Family-Oriented Primary Care?

Physicians are involved daily in managing and treating the illnesses of patients who are linked with, joined to, and living within a larger context—the family. In fact, despite the popular attention given recently to singles living alone or with a nonfamily roommate, still a majority of the American population make their home with other family members (2). The family remains the most basic relational unit in society.

When we speak of the family, each of us develops a picture in our minds of what that means. For some, it is Mom and Dad, brother and sister, as well as the family dog. For others, it may be Mom and Dad, Grandma and Grandpa, and a few aunts and uncles. For still others, the arrangements are less "traditional": single-parent families, gay relationships, adoptive families, remarried families. Beyond that, there are those who feel their truest family is found in a religious community or among a set of friends. All of us have a personal sense of what the family is, but when it comes to defining the "average American family," the task becomes more difficult.

The television stereotype of the American family in the 1950s, which was comprised of a working dad, a mother at home, and one or more children, constitutes only 13% of American households (3). What have emerged in the 1970s and 1980s are more single-parent families and "nonfamily households," which are composed of single persons or persons living with nonrelatives (4). The American family is a mix of couples (30%), two parents and children (28%), single-parent households

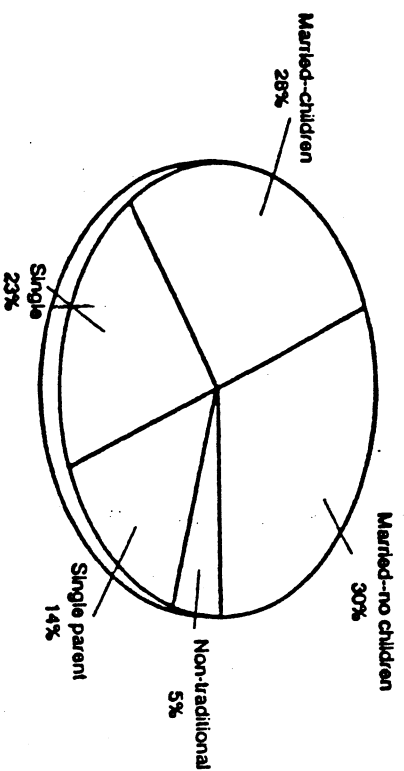


FIGURE 1.1. The American Family

(14%), and nonfamily households (28%). (See Figure 1.1.) Even with these societal changes, it is the family, however constituted, that addresses the individual's need for physical and emotional safety, health, and well-being. Research supports the view that the family plays a vital role in the health and illness of its members. (See Chapter 2.) Since the nature of the American family is evolving, our understanding of it also needs to evolve in order to capture its rich diversity.

We define *family* as any group of people related either biologically, emotionally, or legally. The family-oriented physician gathers information about family relationships, patterns of health and illness across generations, emotional connections with the extended family, and life cycle transitions in order to understand the patient within his or her larger context. In daily family practice, though, the family physician is most often involved with family members who live within the same household. Even though involvement of nonhousehold family members can be important to a patient's medical care, the household is most often the primary focus of the family-oriented physician's care (6). It is important for the physician to encourage the whole household to register with him or her. In this way the physician has direct access to the people who may influence each other's illness and health most.

Without considering the patient in his or her family context, the physician may inadvertently eliminate not only a wider understanding of illness, but a broader range of solutions as well. "Family-oriented primary care" does not mean the physician always sees entire households together. Rather, by "family-oriented" we mean an approach or way of thinking that a physician can bring to any patient encounter, even without accompanying family members. We will address both treating a patient with family members involved and treating the individual patient from a family perspective. This approach involves thinking about a symptom or problem in the context of the whole person and the person's significant

others. At times this way of thinking may mean the inclusion of other important persons in the assessment and treatment process, at other times it may not.

We do not advocate family-oriented primary care because we believe that the family alone can cure disease. Instead, we believe – and research is beginning to support – that planned and purposeful family participation in health care improves health care for the patient, family, and, also, the physician. Not including family members can at times run the risk of incurring roadblocks or, at least, detours on the road to effective and efficient primary care. Including family members can mean the physician has enlisted his or her most potent ally in the treatment of his or her patients. We now turn to the basic premises that underpin this manual, illustrate them with case examples, and then describe the level of skills presented in subsequent chapters.

Basic Premises of Family-Oriented Medical Care

A family-oriented approach to medical care incorporates, expands upon, and, at times, differs from a biomedical approach. Some of the basic premises of a family-oriented approach include:

Premise #1: Family-oriented medical care is based on the biopsychosocial model. The biomedical model, based primarily on molecular biology, assumes that disease can be reduced to "measurable biological variables" (7). The task of the physician operating from a biomedical approach is to analyze and eliminate all factors in the development of illness until the simplest biological elements are identified. The disease-producing factors are isolated and treated as the primary causes of the problem. The central problem with the biomedical approach is that it focuses on biological factors to the exclusion of social and psychological factors, a focus based on the belief that complex situations can be explained entirely by biology. Physicians educated in a narrow biomedical model are more likely to be overly reductionistic and will conceptualize illness from one vantage point. For example, from a biomedical perspective, the cause of tuberculosis is the tubercle bacillus, yet the dramatic decline in the incidence of the disease has resulted from public health measures and improvements in social environment, not from the introduction of antitubercular drugs (8). The physician who defines disease within somatic boundaries alone will miss the impact of other factors, such as the person, the provider-patient interaction, the family, and the social setting, and how these factors may be connected in the creation of symptoms. The biomedical approach is a paradigm that fosters the view that "the body is sum of its parts, separate from mind and impervious to the influences of external forces" (9). A biopsychosocial approach recognizes that psychosocial factors can play an important role in health and illness as biological factors.

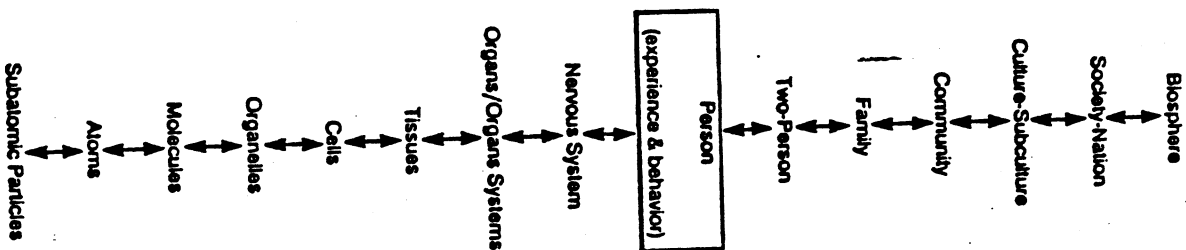


FIGURE 1.2 Systems hierarchy. From: Engel, GL: The clinical application of the biopsychosocial model. *Am J Psychiatry*. Copyright May 1980. The American Psychiatric Association. Reprinted by permission.

The biopsychosocial model, as presented by Engel (7), places illness within a larger framework involving multiple systems. To understand a disease the physician must not only attend to the biological contributors (molecules, cells, organs), but also to the person, the family, the patient-physician relationship, and the social context. (See Figure 1.2.) Rather than being discrete unrelated factors, these various elements are interrelated in such a way that changes in any one level can have an effect on the others. The relationship among these various levels involves continuous and reciprocal feedback.

Medalie describes and illustrates how the various levels in the patient's experience interact (10,11). Each level responds and adjusts to changes in other levels. In that way, stability is maintained through a process of change; much the same as a tightrope walker keeps his or her balance by making frequent shifts and adjustments (12). Dym (13) illustrates this process with a simple case of childhood asthma.

In John and Mary's relationship, John drinks frequently. When he drinks Mary criticizes him. Their son, Harry, 14, unable to deal with the stress leaves the field. As the fight continues, George, 11, becomes more anxious and has an asthma attack. Mary shifts her focus to George and gives him an inhaler. She then blames John who feels guilty. He leaves and the fight stops. The next day he drinks again and the cycle continues.

From a biomedical perspective, the illness is the asthma. From a biopsychosocial perspective the illness is the problem-maintaining relational pattern that fosters a biopsychosocial symptom: wheezing. For a family-oriented physician the primary focus of diagnosis is the multilevel cycle in which the symptom plays an integral part. One of the most important issues in settling on a treatment plan is deciding at which level or levels to intervene (14).

Premise #2: The primary focus of medical care is the patient in the context of the family. The physician who operates from a biopsychosocial perspective focuses on the patient in the context of the family. While this is the starting point of medical care, it does not eliminate consideration of the other multiple levels included in a biopsychosocial approach, levels ranging from molecules, cells, organs, and organ systems to community, culture, society, and biosphere (7). Rather this focus highlights the patient's family context as the primary arena in which medical care issues typically are addressed.

Leaders in the field of family medicine have disagreed on the efficacy of considering the family as the "unit of care" (15-20). There are those who feel the individual is the primary "unit of care," while others argue for the family. We feel this argument is not useful because in a reductionistic way it pits two levels of the biopsychosocial model against each other, that of the "individual" vs the "family," and forces a choice of what

will be the "unit of care." While a physician might choose to intervene primarily at only one of these levels in a given case, to argue for only one of them to be the sacred "unit of care" results in conceptual confusion. (What does it mean for the family to be the "unit of care"? It is also antithetical to the interrelationships among levels that are fundamental to the original meaning of the biopsychosocial model. For that reason we have chosen to think of the patient in the context of the family as the "focus" rather than the "unit" of medical care. From this perspective, the physician is reminded of the importance of the person as a biological and emotional entity as well as the significance of the family's influence on illness and health. For example,

Billy Smith's diabetes was first diagnosed at the age of 13 when he was admitted to the hospital with diabetic ketoacidosis. He adjusted well while in the hospital and shortly thereafter began to manage his own insulin and diet. An only child, Billy received support from his parents, especially his mother who did not work outside the home. Billy's diabetes was stable until his senior year in high school, when he began to spill large amounts of glucose in his urine. His blood sugars were often in the 300's. Billy claimed to be taking his insulin and sticking to his diet. But his situation worsened until he was finally admitted to the hospital to get his diabetes under control.

In cases such as this, the family-oriented physician explores family issues to see how they may influence or be a resource in a crisis. As part of this process, four considerations influence family-oriented primary care:

a) The family is the primary source of many health beliefs and behaviors. The initial appraisal of physical symptoms is usually made within the family and is based upon family beliefs about health. Many families have a health expert, often the oldest female. The family health expert often makes an initial health assessment and treatment plan and decides whether a physician should be consulted. In our case, for example, it was Mrs. Smith who typically made the first contact with Dr. B.

Many health behaviors and risk factors are shared by members of a family. Children are more likely to smoke if their parents smoke (21). Most families share the same diet, which along with genetic influences result in elevated cholesterol levels occurring within certain families (22). A family approach to health promotion and risk reduction is therefore likely to be more efficient and cost effective (23).

b) The stress that a family feels when going through developmental transitions can become manifest in physical symptoms. The family-oriented physician is sensitive to the impact of life-cycle changes on the health of family members. Marriage, birth of the first child, adolescence, leaving home, midlife, death of a parent, retirement are all normal developmental transitions in the life of a family (9,24). Due to the stress that can occur during these periods, the health of family members may be more vulnerable to illness.

The Smiths were going through three significant transitions simultaneously. Mr. Smith has made a career shift at midlife. Mrs. Smith has experienced the death of her mother. And Billy, soon to graduate from high school, was facing the issue of leaving home. Each family member was under tremendous strain. The family as a whole was being transformed by the demands these changes are placing upon it.

c) Somatic symptoms can serve an adaptive function within the family and be maintained by family patterns (25). Dr. B. learned that Billy had a very close relationship with his mother. Mrs. Smith was protective of her son, and Bill depended on his mother's support during his illness. Mr. Smith supported the family primarily through his role as breadwinner and provider. While Mr. and Mrs. Smith were not very close, Billy and his father were able to maintain a good relationship. In the year prior to the acceleration of his illness, Mrs. Smith's mother died, and Mr. Smith had been traveling more since receiving a promotion. Billy was also making plans to leave home for college. Mrs. Smith's needs for closeness increased because of the loss of her mother. Her neediness coincided with her husband's frequent absence. Billy found himself in the position of having to meet his mother's needs while feeling angry and frustrated over his father's absence. It was during this time that Billy developed symptoms. As his symptoms worsened, Mr. Smith began to curtail his traveling. Mr. and Mrs. Smith also began to pull together to try to help their son.

Billy's symptoms can be understood as a barometer of the pressure felt within the family. In a sense, the symptoms were both a problem and a solution. They were obviously a problem in that they presented a challenge to his health and well-being and they created great concern for his parents who loved him. But Billy's symptoms may also be seen as a solution in that they brought Billy's parents together to care for him, thus stabilizing their marital difficulties. The symptoms kept Billy from leaving home too quickly at a time when he was clearly concerned about his parents; and they sounded an alarm for the alert physician that the whole family was in need.

Studies by Salvador Minuchin, a leader in the family therapy field, have shown that increased family stress can adversely affect the management of chronic childhood illnesses (26-28). In particular, he demonstrated that when diabetic children are involved in their parents' conflicts, the stress resulted in an acute rise in free fatty acids and worsening of the diabetic control (see Chapter 2).

d) Families are a valuable resource and source of support for the management of illness. Physicians do not treat illness: they recommend treatment that is usually carried out in the home by the patient and family members. Physicians must rely upon the assistance of the family in management of most chronic illness.

In Billy's case, he had taken responsibility for his insulin diet with the support and supervision of his parents. As Dr. B. advised this

recent crisis, he once again engaged the parents in planning for the management of their son's illness. Despite their differences, Mr. and Mrs. Smith's commitment to their son made planning for and carrying out his treatment possible.

Dr. B's approach to Billy's diabetes takes not only his symptoms into account but the family context as well. It highlights how the family is a factor in both illness and health and sets the stage for utilizing the family as a resource in developing and carrying out a treatment plan.

Premise #3: The patient, family, and physician are partners in medical care. In a biomedical approach the physician uses a process in which various factors are eliminated or ruled out until the most critical biological factors emerge (29). Unfortunately, what also may get eliminated is the person as well as other supraperson levels that may contribute to the illness (29). Since family-oriented physicians consider multiple systems when diagnosing and treating illness, the patient and family are very important resources. It is through these people that the physician gains the most significant information for understanding symptoms and planning treatment. In this way, the family is a natural partner in medical care.

The perspective of partnership destroys what Doherty and Baird have called "the illusion of the dyad in medical care" (3, p. 12). The illusion is that medical care only involves a one-to-one relationship between physician and individual patient. Doherty and Baird point out that except in the most rare situation the family is involved in what takes place between physician and patient. Even when the family is not physically in the room, the patient's role within the family, the family's expectations of medical care, and the family's relational patterns as they pertain to health and illness play a part in what transpires.

In place of a dyadic approach, Doherty and Baird propose a "triangular perspective" (3, p. 13). This triangle involves the physician, patient, and family working in a medical-care partnership. Together they define what needs to be done. This includes identifying symptoms, establishing a treatment plan, and clarifying responsibilities. When this partnership is not in place, medical treatment can go awry.

Dr. L prescribed medication and a low-salt diet for Mr. Samuel's hypertension. Mr. Samuel's parents, with whom he lived, had doubts about the efficacy of medical treatment in general. They questioned the medication and also felt the diet would mean their lifestyle would have to change as well. Mr. Samuel was caught between opposing expectations from his physician and his parents. He resolved the dilemma by complying with the treatment plan only in part. He took his medication irregularly and followed his diet for a few days. Ironically, partial compliance convinced both Dr. L and the family that each v. Dr. L saw it as confirmation that the patient must try harder. The f. was convinced that the treatment wasn't working. Both sides escalated

their positions and Mr. Samuel continued his compromise. In the meantime, his blood pressure remained elevated.

Dr. L soon recognized the situation and invited the patient's parents to come in with their son. Dr. L explained their son's hypertension and the rationale for the treatment plan. He enlisted their help, clearly indicating that they could bring about some change for their son. Mother was utilized as an expert on diet. The parents gave their "permission" for their son to take the medication.

The role of the family in a patient's compliance with medical treatment is well documented. (See Chapter 2.) The family-oriented physician engages the patient and the family as an ally and a resource not only around compliance issues but for medical care in general.

Premise #4: The physician is seen as "a part of" rather than "apart from" the treatment system. A traditional biomedical approach supports physicians being objective outsiders who assess, diagnose, and treat their patients' illnesses. One important factor in medical care that can be missed by this approach is how physicians may influence and be influenced by their patients' behavior. For example, when treatment does not go well, physicians may see their patients as "difficult" or "non-compliant." How the interaction between physicians and patients influences the course of treatment is not considered adequately.

Physicians who operate from a systems or biopsychosocial perspective believe that "the observer constantly alters what he observes by the obtrusive act of observation" (12, p. 129). Biopsychosocially oriented physicians observe the interaction between themselves and their patients. In that sense they understand themselves as part of a circular process in which their behavior contributes as much to what transpires as their patients'. Consequently, when treatment does not proceed well despite biomedical interventions, these physicians will consider the interaction of additional parts of the overall treatment system. This includes how their interaction with the patient and family system may unwittingly contribute to rather than relieve the problem.

Mrs. Jackson brought Mary, age 11, to the doctor's office for the third time in three months with symptoms of a sore throat. Dr. K, alert to larger, systemic issues, invited Mr. and Mrs. Jackson in to discuss their daughter's recurring symptoms. In the course of the interview, she learned that Mr. Jackson had been working very long hours and some weekends for the past six months. Mrs. Jackson was very upset that her husband did not spend more time with her and with Mary. Mrs. Jackson complained that she was always the one to leave work if Mary was in need of care and that her husband did not help out much at all. Mr. Jackson said he could not control his work schedule and did not feel he needed to be more available. Mary said she just didn't feel well and things weren't the way they used to be at home.

Dr. K quickly realized that her exclusive focus on Mary's symptoms in the past two months may have become part of an ongoing argu between Mr.

and Mrs. Jackson over Mr. Jackson's work and involvement in the family. If Dr. K continued to focus only on the biomedical problem, more fuel would have been added to the fire of Mr. and Mrs. Jackson's disagreement and Mary's resultant stress. By including the family, Dr. K saw the larger picture and recognized how she fit into it. She then treated not only Mary's sore throats, but encouraged Mr. and Mrs. Jackson to resolve their differences regarding her work. This was successfully done in several primary care counseling sessions.

It is important for physicians to be aware that they are a part of the larger treatment system. When treatment is faltering, it is useful for the physician to raise questions about how his or her own involvement with patients and families may contribute to patterns that maintain rather than eliminate the problem. A change in the physician's behavior may help facilitate change throughout the system. In the case of the Jackson family, calling a family meeting began to shift the focus from a narrow biomedical perspective to one that respected multiple factors. Dr. K changed her behavior, i.e., she called a family meeting, and involved the family in treatment in a qualitatively different way.

Developing Skills for Family-Oriented Medical Care

Given our basic premises about the family and primary care, our goal is to develop the skills necessary to implement family-oriented medical care. Doherty and Baird describe five levels of physician involvement with families (30). Level One involves minimal emphasis on the family. The family is included only when necessary for practical and medical/legal reasons. At Level Two, the physician is primarily biomedically focused and communicates regularly with the family about medical issues. The physician functioning at Level Three not only gathers information but addresses family stress and feelings by actively eliciting family feelings in a supportive way. At Level Four the physician not only gathers information and deals with family affect but intervenes in ways that may alter the family's interactional patterns. The physician at this level has an understanding of family systems theory and a grasp of the skills to counsel the families to make constructive changes. Level Five is family therapy, which addresses more deeply rooted family patterns of dysfunction. Most physicians (except those who received postresidency training in family therapy) will refer families who need this level of intervention to trained family therapists.

This manual focuses primarily on developing skills at Levels Two through Four. We will mention the importance of Level Two—basic communication with the family. We will encourage physicians to use the skills involved at Level Three when it is important to elicit family feelings and deal with them in a supportive manner. Many physicians already use skills at Levels Two and Three. The goal of this book is to

increase skills and comfort with Level Four—where the physician is able to assess family interaction, utilize family resources and when necessary engage the family in primary care counseling in order to treat illness in the most effective, efficient way. In so doing, we hope to move family-oriented primary care farther along the continuum (31) from an exclusively biomedical approach to a biopsychosocial approach.

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PROTOCOL

Basic Premises of Family-Oriented Primary Care

We define "family" as any group of people related either biologically, emotionally, or legally. While involvement of nonhousehold family members can be important to a patient's medical care, the household is more often than not the primary focus of the family-oriented physician's care.

1. Family-oriented medical care is based on the biopsychosocial model.
2. The primary focus of medical care is the patient in the context of the family.
 - a. The family is the primary source of many health beliefs and behaviors.
 - b. The stress that a family feels when going through developmental transitions can become manifest in physical symptoms.
 - c. Somatic symptoms can serve an adaptive function within the family and be maintained by family patterns.
 - d. Families are a valuable resource and source of support for the management of illness.
3. The patient, family, and physician are partners in medical care.
4. The physician is seen as "a part of" rather than "apart from" the treatment system.

How Families Affect Illness

Research on the Family's Impact on Health

A basic premise of the biopsychosocial model is that various subsystems (biological, individual, family, community, etc.) impact each other in ways that affect both health and illness. Clinical experience supports the premise that families influence and are influenced by the health of their members and that family-oriented primary care can lead to better care and improved health for both the individual and the family as a whole. However, assumptions and experiences that point toward a new approach to medical care should be scientifically validated through empirical research. This chapter will examine some important lines of research on the family's impact on health. While much of the family and health research suffers from conceptual and methodological problems (1), there is now a body of well-designed studies and randomized controlled trials (see Table 2.1) which demonstrate that the family has a powerful influence on health. The clinical implications of this research are presented in the Protocol section of the chapter. This research lends support to the contention of family-oriented medical care that a partnership among physician, patient, and family may provide the most effective and efficient form of health care.

Three areas of research on the family's impact on health will be reviewed: the influence of family stress and support on overall mortality, the family's influence on cardiovascular risk factors and the prevention of heart disease, and the impact of family functioning on the course of chronic disease. Research in these areas have produced the most substantial and consistent evidence for the importance of the family and are particularly pertinent to the practicing physician. More comprehensive reviews are available (2-4) for those who are interested. This chapter does discuss any of the excellent and voluminous research on

Table 2.1. Randomized Controlled Trials of Family Interventions in Physical Illness

Study	Illness	Intervention	Results
Lusk 1979 (70)	Asthma	Family therapy	Improvement in symptoms and thoracic gas volumes
Clark 1981 (93)	Asthma	Family education	Less fear and better management of illness
Gustafsson et al. 1986 (94)	Asthma	Family therapy	Improvement in overall pediatric assessment
Baranowski 1982 (95)	Cardiovascular risk factors	Multifamily support groups	More supportive behaviors to change diet & exercise
Earp 1982 (96)	Hypertension	Family involvement in home visit	No effect
Morisky et al. 1983 (67)	Hypertension	Family support	57% reduction in overall mortality
Brownell 1978 (97)	Obesity	Spouse involvement	Maintained weight loss
Saccone 1978 (98)	Obesity	Spouse reinforcement	Increased weight loss
Wilson 1978 (99)	Obesity	Family involvement	No effect
Pearce 1981 (100)	Obesity	Spouse involvement	Greater weight loss and maintenance
Brownell 1983 (101)	Obesity	Mother involvement	Group with mother and daughter seen separately lost the most weight

families and mental health: in this area, the reader is referred to reviews on schizophrenia (5), depression (6), alcoholism (7), drug abuse (8), chronic pain (9), and eating disorders (10).

Family Stress

Stress has become widely accepted by patients and physicians as influencing health. Patients often explain to their physicians that they are "under a lot of stress" and that their ulcer, back pain, or headache is "acting up." However, stress is difficult both to define and to study (11). One successful method for studying stress and health has been to examine

the relationship of stressful life events to illness. In 1967, Holmes and Rahe (12) developed a life event scale by asking a random sample of the population to rank how stressful they perceived each of 43 common life events to be. Many retrospective and prospective studies using this scale have shown that an increase in stressful life events precedes the development of a wide range of different diseases (13).

Most of the events on the Holmes and Rahe scale occur within the family, and 10 of the 15 most stressful events are family events. Since children are likely to be affected by this stress, a number of studies have looked at the relationship of family life events and child health. Meyer and Hagererty (14) found that chronic stress was associated with higher rates of streptococcal pharyngitis, and that 30% of the strep infections were preceded by a stressful family event. In a study conducted in a day care center, children who experience more stressful life events had longer but not more frequent respiratory illnesses (15). A prospective study of over 1000 preschoolers found that family life events were strongly correlated with subsequent visits to the physician and hospital admissions for a wide range of conditions. Children from families with more than 12 life events during the four-year study period were six times more likely to be hospitalized (16).

The death of a spouse is the most stressful common life event, and the health consequences of bereavement have been extensively studied (17,18). From examining U.S. census data, Kraus and Lilienfeld (19) found that young widowers had 10 times the normal death rate for many illnesses. In a classic prospective study, Parkes et al. (20) followed London widowers for nine years after the death of their spouses. The men had a forty percent higher mortality rate during the first six months of bereavement when compared to the general population. A population study of 4032 widowed persons (21) found that when potential confounding variables (especially smoking and socioeconomic status) were controlled for, widowers, but not widows, had increased mortality rates, which persisted throughout the 10 years of the study. However, widowers who remarried had a lower death rate than the control, nonwidowed group, suggesting that marriage had a protective effect on health. In a study of 96,647 widowed persons in Finland, death rates were highest and twice the expected rate during the first week of bereavement (22).

Divorce or marital separation is also an extremely stressful event, and is ranked second on the Holmes and Rahe scale. Several cross-sectional studies (23-25) have demonstrated that divorcees have a higher death rate from all diseases than single, widowed, or married persons. However, research has also shown that chronic physical illness has an adverse effect on marital satisfaction (26,27) and may eventually lead to divorce. Prospective studies of divorce and health are needed to determine if divorce is cause or effect.

Recent research in psychoimmunology has suggested one of several possible biological mechanisms for the adverse health effects of bereavement and divorce. Studies in animals and humans reveal that stress can lead to immunosuppression and an increase in illness (28,29). Two well-controlled studies demonstrated a decrease in cellular immunity (T-lymphocyte stimulation) during bereavement (30,31). However in a third study, T-cell function was reduced only in those bereaved subjects who were clinically depressed (32). Divorced or separated women have significantly poorer immune function than sociodemographically matched married women (33). Among the married women in the same study, poor marital quality correlated with both depression and decreased immunity. Immune function is also impaired in major depression, and researchers have suggested that changes occurring in the central nervous system during depression may be a final common pathway (29).

Family Support

Although family stress can have harmful effects on health, family support can be beneficial. Social support can be defined as "the emotional, instrumental and financial aid that is obtained from one's social network" (34). An extensive body of research has demonstrated that social networks and supports can directly improve health, as well as buffer the adverse effects of stress (35,36). Furthermore, the family has been found to be the most important source of social support.

In a seminal study of over 6000 adults, Berkman and Syme (37) showed that social networks were a major predictor of mortality over a nine-year period, independent of socioeconomic status, previous health status, or health practices. The most socially isolated adults had more than twice the death rate of the least-isolated group. Marital status and contacts with relatives and friends were the most powerful predictors of health. A similar study (38) confirmed the strong association between social isolation and mortality, but for men only. Again, the family components of social support were the most predictive. In a six-year follow-up study of 17,433 Swedish men and women, those with the fewest available social contacts had over three times the death rate of those with the most social contacts (39).

Studies of social supports in the elderly have shown that the relative importance of different aspects of family support may change over the life span. Two studies found that older persons with impaired social supports have two to three times the death rate of those with good supports (40,41). Unlike studies of younger populations, marital status was not associated with mortality. The presence and number of living children were the most powerful predictor of survival. This finding suggests that

adult children become the most important source of social support in the elderly.

Family supports play a particularly important role in the outcome of pregnancy. Highly stressed women with low family and social supports have higher rates of obstetrical complications (42,43). Women who live apart from their families deliver smaller babies than those who live with their partners or families of origin (44). However, those women who are excessively close or enmeshed with their extended families also tend to deliver smaller babies, suggesting that the quality as well as the quantity of family support influences health. Ramsey and colleagues have hypothesized that the extended family's overinvolvement during pregnancy may be detrimental by not allowing enough autonomy or psychological space for a new family member (44).

These lines of research clearly demonstrate that family support and family stress, especially bereavement, can have a powerful influence on overall mortality. An understanding of the family and their potential sources of stress and support can provide the physician with ways to reduce family stress, bolster family supports, and improve health.

Cardiovascular Risk Factors in Families

Heart disease remains the leading cause of death in the U.S., and a major target of preventive medicine (45). Changes in lifestyle can substantially reduce the risk of heart disease, but are difficult to accomplish. Several studies have shown that there is a high concordance of the cardiovascular risk factor within families (46); that is, family members are more likely to share the same risk factors including smoking, obesity, hypercholesterolemia, and hypertension, than would be expected by chance. This sharing of risk factors occurs both between spouses and among parents and their children. For example, the Framingham Heart Study found a higher than expected concordance between spouses for blood pressure, cholesterol, triglyceride, blood sugar, smoking, and lung function (47).

The sharing of cardiac risk factors within families can be explained by several different mechanisms. Family members can influence each other's lifestyle and health habits. Adolescents are much more likely to smoke if either of their parents smoke (48). Families usually eat a similar diet, and therefore similar amounts of salt, saturated fats, cholesterol, and even calories. An emphasis on physical fitness and maintaining ideal body weight is often a shared family value.

Since genetics can influence some of these risk factors, similarities between parents and children may be inherited. While a recent study of children concluded that obesity in children is largely deter-

mined by genetics (49), other studies have demonstrated a significant effect of the familial environment (50,51). One study of twins demonstrated that most of the concordance of cholesterol levels is due to similar diets (52).

Spouses may share cardiovascular risk factors because they married someone with similar habits. This tendency to marry someone with the same traits or behaviors is quite common and is called assortative mating. Smokers tend to marry other smokers (53), and couples tend to smoke the same number of cigarettes per day (54). Obese men tend to marry obese women. Marital partners may even choose each other (consciously or unconsciously) based upon their dietary or exercise habits. In the Framingham study, the concordance of risk factors between spouses did not increase over time, suggesting that these similarities existed at the time of marriage (47).

Whatever the cause of this phenomenon, it has major implications for health care providers. If one member of a family has a particular cardiovascular risk factor, other family members are likely to be more difficult to change if it is shared by other members of the family. Smokers are more likely to stop smoking if no one else in the family is a smoker (55) and remain abstinent longer if their spouse or friends do not smoke (56,57). Changing one member's risk factor may have a ripple effect and influence the entire family. For example, if one family member starts an exercise program, other family members may want to join in. Smoking couples tend to quit smoking at the same time (54). An intervention designed to change the risk factors within the family rather than in only one individual may be more successful, time efficient, and cost effective.

The ability of an individual to make lifestyle changes and reduce the risk of cardiovascular disease is strongly influenced by the support of family members. Several studies have demonstrated that support from the spouse is associated with successful smoking cessation (55,56). In one smoking cessation program (57), smokers who had the cooperation and reinforcement of their partners had lower relapse rate, while "nagging" and "policing" by the partners had the opposite effect. In a study of an exercise program for men with multiple cardiac risk factors (58), those men whose wives had positive attitudes about the program were twice as likely to complete the program than those men whose wives were neutral or negative.

The family's health beliefs about prevention will influence their support for changing risk factors. As part of a cholesterol-reduction study, Doherty and colleagues (59) examined the relationship of spouses' support and health beliefs to compliance with medication. The wife's beliefs regarding how susceptible she thought her husband was to elevated cholesterol were correlated with both her support and her husband's compliance with a cholesterol-lowering drug. In addition, the wife's

interest in the program and reminding her husband about medicine or diet correlated with compliance, while nagging about medicine was negatively correlated with compliance.

An unhealthy behavior sometimes plays a role within a family that can hinder attempts to change the behavior. For example, studies suggest that eating behavior and obesity itself play an important homeostatic function within many families (60). In a survey of eating behavior within families, 25 percent of mothers reported that they used food as a reward for their children and 10 percent used it as punishment (61). In one weight-reduction program, 91 percent of the spouses of obese women reported that they wished their wives would lose weight, but only 49 percent were willing to help (62). Fifty-three percent of the men anticipated that weight loss would have an adverse effect on the marriage due to loss of eating as a shared activity, loss of power in marital conflicts, and concern over marital commitment and sexual fidelity. During recorded mealtime conversations, these husbands were seven times more likely to talk about food than their dieting wives, and four times more likely to offer food to the other. The men criticized their dieting wives 12 times more often than they praised them. When health-related behaviors, such as eating, serve important functions in the family, these behaviors may be resistant to change unless attention is paid to how changing the behavior will affect the family.

The family can have a significant effect on the treatment of obesity. Several randomized controlled trials of weight reduction have demonstrated that spouse or partner involvement in weight reduction programs can significantly improve results (63-65). These studies have used a behavioral paradigm in which family members provide immediate and long-term reinforcement for weight loss or dieting. When the partner participates in the weight reduction program, the obese individual is not only able to reduce more weight, but is able to maintain the weight loss.

Despite the fact that hypertension is relatively easy to identify and treat and that adequate treatment significantly lowers the risk of heart attacks and strokes, only one-fourth of all hypertensive individuals are under treatment and only one-half of those under treatment have their blood pressure adequately controlled (66). Compliance with medication is a major problem in the treatment of hypertension and reduction of cardiovascular disease. In a randomized controlled study, Morisky and colleagues (67) demonstrated a dramatic effect of family involvement on hypertension compliance and overall mortality. They studied the impact of three different educational interventions (brief individual counseling, instructing the spouse or significant other during a home visit, and small patient group sessions) on appointment keeping, weight control, and medication compliance. Involving the spouse not only improved medication compliance, but resulted in a significant reduction in

blood pressure and overall mortality. Overall the experimental groups had a 57 percent overall reduction in mortality compared to the controls, and those groups that received family education tended to do the best. The family intervention was included in this study after a survey indicated that 70 percent of the clinics hypertensive patients wished that family members knew more about hypertension (68). Based upon this and other studies of the role of social supports in improving compliance, the National Heart, Lung, and Blood Institute has stressed the importance of "the help that patients receive from their family and friends to carry on with their treatments" (69).

This body of research demonstrates that there is strong evidence for both the healthy and unhealthy influences by families on cardiovascular risk factors. Numerous randomized controlled trials have demonstrated that family involvement improves the results of weight reduction and one study shows a similar result for hypertension control. Similar studies are needed for exercise programs, smoking cessation, and dietary changes (low salt and cholesterol). Despite the proven efficacy of a family approach to prevention, health-care providers remain focused on the individual. A major challenge to the health profession is to become more effective in health promotion and to incorporate a family approach to prevention.

Families and Chronic Illness

In the past decade there has been an increasing number of studies on the influence of the family on chronic illnesses, including research on asthma (70,71), chronic renal failure (72,73), heart disease (74,75), and cancer (76,77). Amongst this research, work on diabetes has shown the most consistent relationship between family functioning and disease outcomes (78-80). Adequate control of blood sugars in diabetes can prevent many of the long-term complications of disease, but is difficult to achieve and maintain. Diabetic control is related both to intrinsic metabolic factors (as in the "brittle diabetic") and compliance with insulin and diet. Several studies have shown that overall family dysfunction is strongly correlated with poor diabetic control (81-83). Most of the families of 30 poorly controlled diabetic children studied by White et al. (84) had numerous dysfunctional psychosocial factors, including absent fathers, poor living conditions, inadequate parental function, chronic family conflict, and lack of family involvement with the diabetes. On the other hand, clear organization in the family has been associated with good metabolic control (85). High parental self-esteem is also associated with good control and is an important mediating factor between family functioning and diabetes (81).

How emotionally close or cohesive a family is seems to be particularly important for the care of diabetics. Both low cohesion or disengagement and high cohesion or enmeshment have been associated with poor blood sugar control. (See Chapter 3 for discussion of these family systems concepts.) Fischer and Dolger (86) identified two common maternal reactions to diabetes: overprotection and rejection. The overprotective parent had either a submissive or rebellious adolescent diabetic, while the rejecting parent had a resentful and belligerent child. In a carefully controlled study, Anderson and colleagues (87) found that low cohesion and high conflict were associated with poor diabetic control. Parental indifference can result in the worst diabetic control and lead to depression in the diabetic child (88). Thus in emotionally distant or disengaged families, inadequate supervision and parental support results in noncompliance with insulin and diet and poor diabetic control.

Minuchin and his colleagues at the Philadelphia Child Guidance Clinic (89,90) have studied poorly controlled diabetic children from families with high cohesion. These children had recurrent episodes of diabetic ketoacidosis, despite adherence to diet and insulin. When hospitalized and removed from the family environment, their diabetes were easily managed. It appeared that stress and emotional arousal within the family directly affected the child's blood sugar. In studying these families and the families of children with severe asthma and anorexia nervosa, Minuchin discovered a specific pattern of interaction, characterized by enmeshment (high cohesion), overprotectiveness, rigidity, and conflict avoidance. He called these families "psychosomatic families."

To determine how these family interactions can affect diabetes, Baker, Minuchin, and colleagues (91) studied the physiologic responses of diabetic children to a stressful family interview. During the family interview, the children from psychosomatic families had a rapid rise in free fatty acids (a precursor to diabetic ketoacidosis), which persisted beyond the interview. The parents of these children exhibited an initial rise in FFA levels, which fell to normal when the diabetic child entered the room. Minuchin hypothesized that in psychosomatic families, parental conflict is detoured or defused through the chronically ill child, and the resulting stress leads to exacerbations of the illness. In a larger sample of diabetic families, Cederblad and colleagues (92) demonstrated that high cohesion in the mother, rigidity in the father, and anxiety in the high cohesive child were all associated with poor metabolic control. Minuchin and his colleagues (89) have also reported the successful treatment of these diabetics and their psychosomatic families using structural family therapy to help disengage the diabetic and establish more appropriate family boundaries. In all 15 cases, the pattern of recurrent ketosis ceased and insulin doses were reduced.

These studies suggest that the mechanisms by which the family influences diabetic control depends upon the style of family functioning, especially its cohesion. Both high and low cohesion are associated with poor diabetic control. In enmeshed families, diabetic control is physiologically linked to emotional processes within the family. In disengaged families, inadequate family structure and support results in noncompliance. Optimal management of diabetes requires the support and supervision of the family along with respect for individuality and age-appropriate autonomy. While these results suggest specific clinical interventions with each type of families, no controlled studies have been conducted yet.

Conclusion

Research on families and health demonstrates the powerful influence of the family on health and illness. Family stress and support have an effect on overall mortality. Bereavement is associated with an increased risk of death. Spousal support has a direct protective effect on health and buffers the impact of stress. Cardiovascular risk factors are often shared by family members, and a family approach is an effective way to change unhealthy lifestyles. Studies of chronic disease indicate that family dysfunction is associated with poor health outcomes. We are just beginning to understand the relationship of families and health, and much more research is needed. This research should have a sound theoretical base and develop from clinical observations. In addition to research on the impact of families on health, there needs to be studies of the process of family-oriented medical care, including studies on the reliability, validity, and efficiency of different methods of family assessments and the impact of family conferences on patient and family satisfaction and health outcomes.

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PROTOCOL

Implications of Research on Families and Health for Physicians

Assessment

1. Assess stress within the family by obtaining a genogram. Include:
 - a. deaths of significant family members
 - b. illness in the family
 - c. recent divorce or separation
 - d. chronic marital or sexual difficulties
2. Assess coping including:
 - a. how well the individual patient and the family have dealt with stress in the past (obtained from the genogram)
 - b. how they are coping with current stressors
3. Assess resources, including:
 - a. sources of family and social support
 - informational support
 - emotional support
 - financial support
 - b. availability and utilization of supports
 - c. how helpful the patient and family perceive the supports to be
4. Assess role of the health behavior in the family:
 - What function or role does a particular health related behavior, such as smoking or diet, play within the family.
 - What will happen if the behavior or risk factor is changed? Ask "What would it be like for you and your family if you no longer ... smoked? ... were overweight?"

Intervention

1. Screening: When an unhealthy behavior or risk factor is detected, screen the entire family for the same risk factor, even when it is not genetically determined, including:
 - a. smoking
 - b. excess alcohol consumption
 - c. elevated cholesterol
 - d. obesity
 - e. failure to use seatbelts
 - f. drinking while driving
 - g. hypertension
2. Educate the family as well as the patient about the risk factor or illness.

3. Intervene at the family level, when possible:
 - a. Encourage both members of a couple to quit smoking, or all members of the family to reduce the cholesterol in their diets.
 - b. Work to get the patient's spouse to support lifestyle changes or compliance with medication. Block tendencies for spouses to "police" or "nag" the patient.
 - c. Encourage family involvement in the management of the illness, while supporting the patient's autonomy and ultimate responsibility for care.
 - d. Refer severely dysfunctional families with chronic illnesses to a family therapist. Keep the focus of the referral on the diabetes, not on the family problems. Refer for "difficulty controlling diabetes" not "family dysfunction." (See Chapter 15 for more on families and chronic illness.)

CHAPTER 3

Family Systems Concepts

Tools for Assessing the Family in Primary Care

To provide family-oriented medical care it is important for a physician to be able to assess how a family's functioning plays a part in both the illness and the health of its members. Just as a physician must organize and evaluate the signs of physical illness in order to make an appropriate diagnosis, the same is true when considering the emotional, interactional, and historical processes that take place in a patient and his or her family. To do so without benefit of a conceptual framework for understanding the family can be overwhelming.

Doherty and Baird first conceptualized and labeled primary care family assessment and counseling in their landmark volume, *Family Therapy and Family Medicine*, in 1983 (1). Others in family medicine have developed screening instruments and assessment methods that can be useful in primary care such as the Family APGAR (2), the family circle (3), and PRACTICE (4). The family genogram (5,6) borrowed from the family therapy field is an essential tool for the assessment of families. (7).

Family assessment begins at the initial contact with any patient during a routine encounter and involves taking relational factors into account when considering medical problems. This minimal assessment may or may not lead to a family meeting to assess a situation in greater depth. Thus when a physician identifies marital problems, or hypothesizes a link between symptoms of different family members, he or she has made an assessment that may lead to a family meeting to further evaluate the situation (1,4). (See Chapter 5 for a discussion of how to convene the family.) Family-oriented primary care involves a continuum of family assessment from minimal (e.g., routine visits with individual patients) to maximal (e.g., calling a family conference), ending on

Family Systems Concepts

In this chapter we will present family systems concepts and case illustrations that will help the physician: organize his or her thinking about families, identify how families are structured, recognize family interactional patterns and processes, and be aware of family development across time.

The Family

1. **The Family as a System.** Through the application of systems theory, we see the family as more than the sum of its parts. The family is organized by interpersonal structures and processes that enable it to be both stable and adaptable over time.
 - Who are the members of the patient's family?
 - When it comes to daily support, who does the patient consider as family?
2. **Family Stability.** Family stability is the interpersonal process by which the family strives to maintain emotional balance in the system (e.g., a mother who despite significant disability continues to care for her children).
 - What does the family do to maintain balance and security for its members?
 - If change occurs too quickly, what will happen to the family's stability?
3. **Family Change.** Family change is the interpersonal process by which the family adapts, alters, or becomes different.
 - What does the family do to facilitate needed change?
 - If change does not occur quickly enough, what will happen to the family?
4. **The Relational Context of the Symptom.** The presenting symptom is part of a large family and psychosocial context that can influence and be influenced by that symptom. For some acute, self-limited illnesses, a primarily biomedical intervention may be enough for any symptom. But for many medical problems the relational context is important to treatment.
 - How do the patient's symptoms influence the family?
 - How does the family influence the patient's symptom?

Mr. Payne, a 42-year-old factory worker, came to see Dr. M because he had been experiencing more frequent chest pains over the prior two months. Mr. Payne has a history of chronic stable angina that had previously been well controlled with medication. Dr. M's medical evaluation revealed that his

M increased Mr. Payne's medication, ordered an exercise stress test, and scheduled him to return in one week.

At the follow-up visit, Mr. Payne reported that his chest pains were less frequent but still troublesome. Dr. M explained that the stress test was mildly abnormal but unchanged from his previous test, and recommended that he start taking a new medication. Mr. Payne was agreeable to Dr. M's plan but still appeared distressed. Dr. M began to explore what else was occurring in Mr. Payne's life.

He learned that Mr. Payne's wife had started cleaning houses in the last six months to earn some extra income. Mr. Payne's son, Bob, 17, a high-school senior worked with his mother after school. Mr. Payne seemed irritated by how busy his wife was and how little time he had with his son. Mr. Payne felt his main support was his 21-year-old daughter, Mary, who lived and worked in a nearby town. Mary came home to visit on weekends. Three months ago Mary announced she was engaged. Although Mr. Payne liked Mary's fiancé, he felt she was making a decision to marry prematurely. He worried about her future.

Dr. M said he was impressed with how family members cared for and helped each other. He suggested that the family come to an appointment together because they might be a resource to Mr. Payne and Dr. M.

Dr. M's discussion of Mr. Payne's family helped place the symptom in a larger relational context. The family's emotional balance (family stability) had been disrupted by numerous changes and anticipated changes: Mrs. Payne's new job, Bob's eventual graduation, and Mary's engagement. Mr. Payne was experiencing the stress of all these transitions and his symptoms may have been a signal that the family was also having difficulty navigating the changes (family change). Dr. M invited the family in to explore how the family's functioning as a whole might play a part in Mr. Payne's symptoms and their alleviation (family as a system).

Family Structure

5. **Hierarchy.** Hierarchy has to do with how power or authority is distributed within the family (8). Typically, parents have greater authority than children and thus are above them in the family hierarchy.
 - Who is in charge in the family system?
 - Is the family's hierarchy clear and appropriate (e.g., parents in charge of their children) or reversed (e.g., parents controlled by children)?

6. **Boundaries.** Boundaries define different functional subgroups in the family, such as the marital subgroup, the sibling subgroup, the grandparents, etc.

- What are the subgroups in the family?
- Are the boundaries between subgroups (e.g., parents and children) clear and appropriate or confused and problematic?

7. Family Role Selection. Family role selection is the unconscious assignment of complementary roles to members of a family. The roles then function to maintain the stability of the family system (e.g., mother is in charge of discipline; father is the nurturer).

- What roles do family members play, and how do these roles relate to each other?
- Who is the family's expert on illness and health?
- Who is most often the "sick" member of the family?

8. Scapegoat or Noble Symptom Bearer. The scapegoat or noble symptom bearer is identified by the family as the source of its problems, accepts the family's blame, and through his or her symptoms also reflects the dysfunction of the family as a whole.

- Does the family have a scapegoat or noble symptom bearer?
- How do his or her symptoms reflect problems for the family as a whole?

9. Parentified Child. The parentified child is a child in the family, often the oldest, who performs the parental functions when one or both parents have abdicated the role (e.g., an oldest daughter does the cooking and child care because of the mother's chronic disabilities).

- Does a child in the family function as a parent?
 - Have one or both parents abdicated their role?
- 10. Alliance.** An alliance is a positive relationship between any two members of a system (e.g., a mother and father cooperating together).

- What are the important alliances in the family?
- How are alliances between family members viewed by other family members?

11. Coalition. A coalition is a relationship between at least three people in which two collude against a third (e.g., a parent and a child siding against another parent).

- What coalitions exist in the family?
- Who is siding against whom?

Mr. and Mrs. Payne, Mary, 21, and Bob, 17, came to the family meeting called by Dr. M. After Dr. M shared his findings, Mary was the first family member to speak as she expressed her concern about her father's "longstanding" health problems. She blamed her mother for not taking better care of him. Bob quickly defended his mother, saying she had been working very hard and had a lot on her mind. Bob became upset with Mary for attacking their mother. Mrs. Payne told Dr. M that her husband had had health complaints for as long as she had known him. Mr. Payne then said that his chest pains were worse since the last doctor's appointment.

Dr. M could see that the hierarchy within the Payne family was reversed. Mary took charge of the family interaction (parentified child). She a in a coalition with her father against her mother,

the meeting. A good working relationship (alliance) did not exist between Mr. and Mrs. Payne regarding Mr. Payne's health. This was due in part to the confused generational boundaries in the family which contributed to the distance between Mr. and Mrs. Payne. Instead of strong marital and sibling subsystems, both children functioned as protectors of their parents. Mr. Payne was the family's "sick" member; Mary acted as the expert on his health; Mrs. Payne was cast as the uncaring spouse; and Bob was her defender (family role selection). Mr. Payne drew attention away from the family's conflicts by focusing on his chest pains (noble symptom bearer).

Family Process

12. Enmeshment. Enmeshment characterizes a system in which members have few interpersonal boundaries, limited individual autonomy, and a high degree of emotional reactivity (e.g., mother insists on remaining with her adolescent son during his physical and answers questions for him).

- Are family members overinvolved with each other?
- Do family members "feel each others feelings"?
- Do family members seldom act independently?

13. Disengagement. Disengagement characterizes a family system in which members are emotionally distant and unresponsive to each other (e.g., a husband does not tell his wife or children about any of his health problems).

- Do family members have little emotional response to each other?
- Are family members distant or isolated from each other?

14. Triangulation. Triangulation occurs when a third person is drawn into a two-person system in order to diffuse anxiety or conflict over issues of intimacy in the two-person system (e.g., rather than arguing with each other about personal issues, a mother and father express their marital discontent by arguing over parenting their son).

- Do family members talk directly to each other about personal matters?
- Or when emotional issues arise between two members, do they focus on a third family member?

15. Family Patterns. Family patterns are the ordered sequences of interaction that typify how a family functions (e.g., when one spouse pursues, the other spouse withdraws; when a father gets depressed, the family tries to cheer him up, but he gets more depressed, and they become frustrated).

- What sequence of behaviors are being used to solve the family's dilemma?
- Does this pattern make the situation better or worse?

- If worse, what other behaviors might interrupt the sequence or pattern?

After commenting on his health problems, Mr. Payne told his wife how upset he was that she had shown so little interest in their daughter's marriage. Mr. Payne told Dr. M he discussed his wife's apparent disinterest frequently with his daughter who he described as "hurt."

Mr. Payne had developed a very close relationship with his daughter (enmeshment) which at times substituted for the emotional support he felt was missing from his wife. And rather than discussing his own feelings of neglect, Mr. Payne became angry at Mrs. Payne about her "lack of interest" in their daughter's plans to marry (triangulation). Dr. M recognized that whenever family members became upset with each other the focus of attention shifted to health issues or a third family member (family pattern).

The Family Across Time

16. The Family Life Cycle. The family life cycle is the normal process of family development beginning with marriage, pregnancy, launching of children, retirement and ending with death in which specific developmental tasks must be accomplished. (See Appendix 3.1)

- In what developmental stage is the family?
- What are the important tasks that need to be accomplished in this stage?

17. Family Projection Process. Family projection process involves the transmission of unresolved conflicts, issues, roles, and tasks from one generation to another (e.g., the men in each generation never go to physicians for health problems).

- What unresolved issues from past generations may be affecting the family in the present?

18. Intergenerational Coalition. A coalition of two members from different generations against a third member of the family is an intergenerational coalition (e.g., a grandmother and granddaughter against a mother).

- Is there evidence of family members from two different generations colluding against a third member?

Dr. M commented on the many important changes that the family was facing—their son graduating, mother starting to work, and daughter planning to marry. Mr. and Mrs. Payne both agreed that these changes were affecting them. They were hopeful about their children's future but anxious, as well, about leaving. Following this discussion Mr. Payne talked at length about his death five years ago. Mrs. Payne said her husband had never got-

The Payne family was facing the "leaving home" stage in their development (family life cycle). Both children were leaving either for college or to get married within the next several months. This placed increasing pressure on the marital relationship as they faced an "empty nest." The anticipation of these changes or losses also reawakened Mr. Payne's unresolved grief over his mother's death (family projection process). Mrs. Payne's comments about her husband's grief and her own lack of attachment to her mother-in-law led Dr. M to hypothesize that perhaps Mr. Payne and his mother had been in close relationship that excluded Mrs. Payne (intergenerational coalition).

The case of Mr. Payne illustrates how family systems concepts can be used to better understand the interplay between a patient's symptoms and his or her family. Without such conceptual tools a family's interactions can seem confusing at best and frustrating at worst. And while not all the concepts apply to every family, family systems theory does provide a way for a physician to organize his or her thinking about any family. The information gathered by assessing a family as a system, its structure, process, and development across time, can be used to arrive at an effective treatment plan in collaboration with the patient and family.

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Appendix 3.1

The Family Life Cycle

Family Life Cycle Stages	Developmental Tasks
Leaving Home	<ul style="list-style-type: none"> *Differentiate self in relation to family *Develop intimate peer relationships *Establish oneself in work
Couples and Pairing	<ul style="list-style-type: none"> *Form a committed relationship *Realign relationships with extended family to include partner
Pregnancy and Childbirth	<ul style="list-style-type: none"> *Make room for children in the family *Become parents while remaining spouses
Family with Young Children	<ul style="list-style-type: none"> *Form a parent team *Negotiate relationships with extended family to include parenting and grandparenting roles
Family with Adolescents	<ul style="list-style-type: none"> *Shift parent-child relationship to permit adolescent to move in and out of system
Adulthood and Middle Years	<ul style="list-style-type: none"> *Refocus on marital and career issues *Deal with disabilities and death in grandparents *Deal with own aging and mortality
Graying of the Family	<ul style="list-style-type: none"> *Maintain functioning in face of physiologic decline
Death and Grieving	<ul style="list-style-type: none"> *Deal with loss of spouse, siblings, and peers *Preparation of own death

*Adapted from Carter CA, McGoldrick M (eds.): *The Family Life Cycle: A Framework for Family Therapy*, New York: Gardner Press, 1980.

PROTOCOL

Family Systems Concepts

The Family

1. Family as a System
 - Who are the members of your patient's family?
 - When it comes to daily support, who does your patient consider as family?
2. Family Stability (Homeostasis/Morphostasis)
 - What does the family do to maintain balance and security for its members?
 - If change occurs too quickly, what will happen to the family's stability?
3. Family Change (Morphogenesis)
 - What does the family do to facilitate needed change?
 - If change does not occur quickly enough, what will happen to the family?
4. Relational Context of the System
 - How do the patient's symptoms influence the family?
 - How does the family influence the patient's symptoms?

Family Structure

5. Hierarchy
 - Who is in charge in the family system?
 - Is the family's hierarchy clear and appropriate (e.g., parents in charge of their children) or reversed (e.g., children in charge of their parents)?
6. Boundaries
 - What are the subgroups in the family?
 - Are the boundaries between subgroups (e.g., parents and children) clear and appropriate or confused and problematic?
 - How does the family deal with emotional closeness and distance?
7. Family Role Selection
 - What roles do family members play, and how do these roles relate to each other?
 - Who is the family's expert on health and illness?
 - Who is most often the "sick" member of the family?
8. Noble Symptom Bearer/Scapegoat
 - Does the family have a scapegoat or noble symptom bearer?
 - How do his or her symptoms reflect problems for the family as a whole?

9. Parentified Child
 - Does a child in the family function as a parent?
 - Have one or both parents abdicated their role?
10. Alliance
 - What are the important alliances in the family?
 - How are alliances between family members viewed by other family members?
11. Coalition
 - What coalitions exist in the family?
 - Who are the coalition members siding together against?

Family Process

12. Enmeshment
 - Are family members overinvolved with each other?
 - Do family members "feel each other's feelings"?
 - Do family members seldom act independently?
13. Disengagement
 - Do family members have little emotional response to each other?
 - Are family members distant or isolated from each other?
14. Triangulation
 - Do family members talk directly to each other about personal matters?
 - Or when emotional issues arise between two members, do they focus on a third family member?
15. Family Patterns
 - What sequences of behavior are being used to solve the family's dilemma?
 - Does this pattern make the situation worse? If so, what different behaviors might interrupt the sequence or pattern?

The Family Across Time

16. The Family Life Cycle
 - In what developmental stage is the family?
 - What are the important tasks that need to be accomplished in this stage?
17. Family Projection Process
 - What unresolved issues from past generations may be affecting the family in the present?
18. Intergenerational Coalition
 - Is the alliance of family members from two different generations?

CHAPTER 4

Greasing the Wheels Promoting a Working Alliance with Patients and Families

The relationship between families and their physician is the most powerful vehicle for influencing patients about issues regarding health and illness. Physicians influence their patients and patients influence their physicians. The doctor-patient relationship is an essential subsystem of the biopsychosocial approach to treatment. As such, it deserves special thought and consideration, and careful assessment when this alliance is problematic. The way the physician handles his or her part in the doctor-patient relationship can affect a patient's sense of well-being and the likelihood that a patient and family will cooperate with any given treatment plan, not to mention the physician's own sense of job satisfaction. For these important reasons, we will now turn to some pragmatic suggestions for promoting a constructive working alliance with patients and family members. We will focus on the physician's side of this equation because that is what we can alter. Three fundamental interviewing skills enhance the potential for an effective partnership to develop between physician and family: building rapport, structuring the interview, and converting resistance into cooperation.

Building Rapport

Early in an interview both physician and patient test each other. Physicians look for whether a patient will be a clear and reliable source of information about the presenting problem. Physicians also look for some sense of cooperation from the patient. Will the physician and patient easily understand each other and work together, or will the patient require more attention to succeed? While physicians can utilize

their patients, the patients, of course, are checking out their physicians. First and foremost, patients generally assess the physician: Does the physician seem to ask the right questions, order the right tests, prescribe the right medicine, provide some information about the presenting complaint? Does the physician listen attentively and empathize with patient concerns? In this way the patient decides if the physician is competent and understanding.

During this phase of the interview, it is important to focus, almost exclusively, on building rapport. The term used by family therapists to characterize this early phase of rapport-building is *joining* (1). Joining with each individual patient and family member is like oiling an important piece of machinery. If it is well-oiled, the machine is likely to run smoothly and effectively when it is needed. If not, the machine will grind, make a lot of noise, and run inefficiently or sometimes not run at all. Joining, like oiling, is a maintenance task that in and of itself will not produce the desired outcome, but the absence of which threatens the outcome of the interaction.

Joining occurs most consciously in the socializing phase of an interview or conference. It begins with greeting, making contact, and establishing rapport with each person. From an individual perspective, this process involves searching for a common wavelength or language with which to communicate. Searching for commonality may involve commenting on the weather, on a common heritage, or inquiring about the patient's employment. It is finding a respectful way to make a connection, person to person, before beginning the central business of the interview. For example:

- Hello, Mrs. Jones, I'm Dr. Brown. How did you manage to get here today through all that snow?
- Hello, my name is Dr. Brown. Mr. Mancini? That's Italian isn't it? My wife's family came over from Italy.
- I'm glad to meet you, Mr. Hammer. I see from your chart that you are a carpenter. I did some construction work while I was in college. That's tough work.

It is in these beginning interactions that a physician may consciously or unconsciously use different parts of his or her own history or behavior to connect with a given patient. This may be done at the level of content, as in the above introductions, or it may be done at a process or nonverbal level. For example, with a depressed woman, the physician may speak in a low, soothing voice. With a loud, anxious man who just had a myocardial infarction, the physician may speak with strong conviction. With a particularly difficult patient, part of establishing rapport may involve mirroring behavior, such as sitting in the same position, using similar cadence, or mirroring some of the patient's gestures until the patient relaxes or moves to a less uncomfortable position.

Greasing the Wheels

Once a connection has been formed, joining involves listening for the patient's health belief system, their cultural explanations for illness, and, especially, their personal diagnosis of the problem. Understanding the patient's position provides a starting point for negotiating a diagnosis (if you do not agree with their's) and collaborating on an effective treatment plan.

PATIENT: I think I feel some lumps in my neck, Doctor. I want you to check them for me.

DR: So you've noticed some unusual lumps in your neck. Is there anything particular you are concerned about?

PATIENT: Well, sort of. My brother died of Hodgkin's disease several years ago, and I am afraid I may have the same thing.

This is a straightforward example of connecting with a patient's agenda and understanding her own diagnosis so that an acceptable treatment plan can follow.

When interacting with more than one person at a time, as in a family conference, joining also involves being wary of emotional triangles and family coalitions. (See Chapter 3 for an explanation of these concepts.) To be effective, it is important for the physician to develop positive working alliances with both the patient and other family members, rather than being drawn into coalitions with the patient against family members or vice versa.

DR: Thank you, Mr. Howell, for coming in to help me understand your wife's recent problems sleeping.

MR. HOWELL: I don't see how I can contribute. I'm sure my wife has already told you I snore, and she probably told you that's why she can't sleep. But, I doubt it. I've been snoring for years. Maybe if you just gave her sleeping pills, we could all get some rest.

DR: Your viewpoint is certainly important to me. Perhaps we can all work together to solve this problem. I would like to hear both of your perspectives on this sleep disturbance.

Here, Mr. Howell assumed the doctor had already taken sides with his wife. This assumption is frequently made when a patient has a longstanding relationship with a physician that has not included other family members. For this reason alone, it is useful to routinely meet family members early on when seeing a new patient. Not only can you put faces to names when a patient discusses their family, but connections have already been made for future interactions. It can be awkward during an emergency, or in the midst of a serious problem, to have to join with unknown family members. In the above example, the physician focused on Mr. Howell early in the interaction and solicited his view of the problem. He let him know his views would be heard.

worsening the problem. The physician then turned to give Mrs. Howell the same opportunity to be heard without blame or sidetracking.

In the next example, again the physician maintains a flexible position, a position from which he can empathize and support each person in turn.

Dr. Mr. and Mrs. Sweet, I appreciate you both taking the time to come in and discuss your son's recent difficulty keeping his sugars under control. As I've told Ralph, diabetes can be difficult to manage, and we need all the help we can get.

Mr. Sweet: Well, I think if my wife would feed the kid the right foods, we probably wouldn't have a problem. I tell her this, but she won't listen to me.

Mrs. Sweet: Why should I listen to you? You're never home to even know what he eats.

Dr. It's clear you both have a perspective that will be important to hear. You both are obviously concerned about your son or you wouldn't be here today. Let's begin with Ralph and hear what problems he feels he's having sticking to his diet.

The physician maintaining an alliance with each member of this family might result in a productive conversation in which the parents pull together to help their son stick to his diet. But, if Mrs. Sweet and Ralph consistently berate Mr. Sweet, this mother-son coalition might signal to the physician a need to either collaborate or refer to a family therapist. When triangles or coalitions persistently interfere with treatment, a new approach is necessary. Being able to negotiate difficult triangles or coalitions and develop constructive working alliances are important to building both patient's and family member's confidence in the competence of the physician. Not doing so can result in problematic interactions for the physician.

Dr. C had enjoyed working with Mr. Bell over the years. In the last year Mr. Bell's daughter moved to town, in part to be closer to her aging father. Mr. Bell was mildly obese with moderate hypertension. His daughter began bringing him to his doctor appointments and soon was demanding that Dr. C monitor his medication more closely and give her father a "complete physical." While she was quite demanding and difficult to deal with, Mr. Bell remained content with his medical care, did not see additional tests as being important, and defended his doctor to his daughter. Framing Mr. Bell as "the patient" in his mind, Dr. C continued treatment as before and tried very hard to minimize or ignore the daughter's demands and protests.

Unfortunately several months later Mr. Bell had a severe stroke, leaving him comatose. He eventually died. Mr. Bell's daughter had experienced Dr. C as cooperative with what she saw as her father minimizing his health

problems, and so she was furious and blamed Dr. C after the stroke occurred. This difficult relationship between the physician and his patient's family made decisions regarding care both complex and unpleasant, and made grieving after the patient's death complicated for both the daughter and the physician. After this experience, Dr. C vowed to spend more time and energy forming an alliance with the patient's family members with the recognition that dis-counting them often backfires in the long run.

Establishing Leadership in the Interview

Providing leadership by orchestrating a well-organized interview also builds patient confidence in the physician's competence. A well-organized interview means more than just asking open-ended questions so a patient can express his or her feelings. It also means having goals for the interview, a structure and tasks to accomplish these goals, and a clear sense of the responsibilities inherent in both the doctor's and the patient's roles. With regard to these roles, Whitaker, a family therapist, conceptualizes the early stages of a psychotherapeutic relationship as involving struggles around structuring the interview and the initiative for change (2). His view is that the therapist must take responsibility for structuring the interview, recognizing that of necessity the patient is in control of the initiative for change. Whitaker believes that many major therapeutic impasses are the result of confusion over who is in charge of treatment and who is in charge of change. Adapting these concepts to the primary care context, we like to think of the physician as being in charge of the interview and the treatment plan, while recognizing that the family members are of necessity in charge of their own health and recovery. The way a physician chooses to structure an interview is central to the physician role and part of his or her contribution to the success of the treatment.

Ground rules for structuring an interview or conference can help the physician maintain control over the interview, prevent a family member from dominating the discussion, and make the most effective use of time. We think of the physician as needing to direct traffic in a group interview, requiring skills significantly different than what is needed in an individual interview. The following are general rules that help the physician conduct an effective interview:

1. **Allow only one person to speak at one time.** The physician needs to establish leadership during the interview or conference so he or she can protect each person's right to be heard.
2. **Have each person use "I" statements.** Insisting each person in the group speak only for him- or herself prevents any discussion from degenerating into blame and accusation.

PATIENT TO HUSBAND: You're always on my back about my weight. No one could lose weight living with your nagging.

Dr: Can you stick to the rule of only using "I" statements while we discuss these difficult problems?

PATIENT: Well, I'm having a hard time sticking to the diet we previously agreed to.

Dr TO HUSBAND: Dieting is often a challenge for the strongest of us. When do you see your wife doing well with her diet?

In this example the patient quickly moved to blame her husband for her difficulties. By invoking the rule about "I" statements, the physician was able to move the interview back to a nonblaming and more constructive path.

3. **Emphasize strengths.** Even in the most difficult interactions or with the sickest of patients, some resource or strength can be noted and utilized in treatment. This approach boosts people's self-esteem, recognizes positive gains, minimizes conflict, and encourages the family to take as much responsibility as possible for the health of their loved ones.

PATIENT: Well, I'm having a hard time sticking to the diet we previously agreed to.

Dr TO HUSBAND: Dieting is often a challenge for the strongest of us. When do you see your wife doing well with her diet?

HUSBAND: Well, I do notice she seems to do quite well when I'm away on a business trip.

Wife: I didn't realize you noticed. It's easier to eat well when you aren't here.

Dr: I'm very impressed, first, that you, Mr. Jones, were so observant. And then it is clear, Mrs. Jones, that you are able to make some progress eating well when you are on your own. Perhaps you'd like to talk together now about how you could each use these good qualities to your advantage when you are both at home, as is usually the case.

4. **Model this behavior yourself.** The physician, as leader of the interview or conference, sets the tone for the discussion in the way he or she speaks. Using "I" statements, speaking respectfully to each person, and maintaining a belief in the patient and family's ability to mobilize resources to bring to bear on the illness or problem—all these behaviors can be contagious.

Converting Resistance into Cooperation

Cooperation and resistance are interpersonal phenomena. Both are two-way streets. Difficult to cooperate with someone who is uninterested

In a primary care context, this means that both cooperation and resistance are some measure of the goodness of fit between the physician and the patient or family. We prefer the term "cooperation" over the term "compliance," because cooperation implies the collaborative, interpersonal nature of this exchange. Compliance, on the other hand, implies that the physician gives orders that the patient should obey. This authoritarian mind-set can lead to situations in which patients either lie or omit information to protect themselves, maintain the appearance of compliance, and protect their relationship with a valued physician. Cooperation implies an effort on both the doctor's and the patient's parts to express their own and understand the other's point of view.

Cooperation results from many factors, most especially, an established connection between the physician and the patient and family, and an agreed-upon and well-understood treatment plan.

PATIENT: I understand I am to reduce my meal portions and avoid all sweet desserts to bring my diabetes under control.

HUSBAND: Do you recommend the whole family change our diets?

Dr: How do you feel about that?

HUSBAND: I feel I should to support my wife, but I'm also afraid I will end up resenting giving up foods I really like.

PATIENT: I don't expect you to do that.

Dr: Many aspects of your wife's diet are part of good nutrition, so you may want to use this as an opportunity to change some of your family's eating habits. But, it is very important that family members not sacrifice too much or resentments will build. You and your wife can be creative and find alternative foods for her to eat when the rest of the family wants dessert.

HUSBAND: I understand. We will work on this together. Her well-being is important to all of us.

Resistance occurs when the physician and the patient or family become involved in a struggle over treatment. This struggle may be obvious; it may be clear why the patient is not improving. Or, the struggle may be covert; the patient may not be improving and the physician may not realize the patient or family disagrees with the treatment plan and so is not implementing it fully. In the following example, there are hints from the husband that he is not fully supportive of the treatment plan and will leave its implementation solely to his wife.

PATIENT: I understand I am to reduce my meal portions and avoid all sweet desserts to bring my diabetes under control.

Dr TO HUSBAND: How do you feel about that?

HUSBAND: I don't like it, but I guess she has to do what "the doctor" says.

Dr: It is very important to get your wife's diabetes under better control. Losing weight is the most important thing she can do for her!

Dr: You do it your way, even if it's occasionally bad for you?

JANE: Well, maybe.

Dr: How about if I invite your parents in to discuss your diabetes? Perhaps we could find a way for you to be in charge while still reassuring them you are going to be okay.

In this example treatment for diabetes in this teenage girl has become intertwined in her struggle for independence from her parents. When they advise or chide her about taking care of herself, she feels intruded upon and rebels. Trying to manage the treatment without understanding what function it has come to serve in this family is likely to fail.

Clear recognition of what one does and does not have control over as a physician is fundamental to establishing a collaborative, cooperative relationship with patients. While we can offer advice, prescribe medications, recommend treatment, and be persuasive with our patients, in the end we can only directly change ourselves. How our patients will choose to participate in what is recommended is their right and responsibility. In the process of treatment then, we must focus on our own behavior: on structuring the interview in the most useful way, on having the strongest treatment plan possible, on using the patient's and family's strengths and resources to help the patient heal, and on enjoying our work.

Physicians' Personal Issues as Contributions to Resistance

Physicians' personal experiences can be humanizing and result in increased empathy for patients and a wider range of strategies for patient care (4). (See Chapter 23 for a more in-depth discussion of these issues.) However, unresolved personal issues can negatively affect our ability to see patients clearly and to function optimally. This interference in physician functioning is the physician's contribution to resistance and can come from many sources. Cases may resemble our own current family situation in ways that cloud our judgment. A physician whose father just died of a sudden myocardial infarction may begin sending many more patients for catheterization and argue strongly with patients who object. Patient situations may recapitulate our own unresolved family of origin issues (5,6). A physician whose mother was alcoholic may become unusually angry when dealing with alcoholic patients. And less exotic problems such as fatigue, illness, and general energy level can affect our ability to think clearly when a patient appears resistant to what we feel is clearly the correct medical course. Interactions with patients seen early in a given afternoon may influence us in what affect our treatment of patients seen later that afternoon.

Sometimes a patient's or family member's behavior so offends a physician's sense of values that the physician has difficulty forming or maintaining an alliance or developing any understanding of that person's offensive behavior. Cases of physical or sexual abuse or other criminal activity are common examples of situations many physicians find challenging in forming good working alliances with the patients involved. Even a mild suspicion of such problems, or some other breach of the physician's own code of ethics, can contribute to difficulty building therapeutic relationships between the doctor and the patient and family.

Dr. R was a woman active in the feminist movement who enjoyed her obstetrical practice. She was very supportive and capable guiding women through the physical and emotional challenges of pregnancy, labor, and delivery.

Mrs. Hernandez came to see Dr. R at 18 weeks of pregnancy. She spoke broken English, having just moved to this country after meeting her husband, becoming pregnant by him, and marrying him on a trip here to visit her relatives. The pregnancy went along smoothly, though Mrs. Hernandez was clearly stressed by all the changes she had encountered in such a short period of time. Dr. R saw her frequently and was as supportive as she could be.

At 36 weeks, Mrs. Hernandez came in complaining that she was having some light intermittent bleeding that seemed to occur after her husband would insist they have intercourse. Upon questioning, Mrs. Hernandez acknowledged to Dr. R that she did not want to have sex at this point with her husband but that he disregarded her feelings. Dr. R had met Mr. Hernandez only briefly, but felt his behavior was reprehensible and unacceptable. She took out a prescription pad and wrote out a prescription stating Mrs. Hernandez was to engage in no sexual intercourse until after delivery for medical reasons.

Mr. Hernandez had been vocal about his reluctance to attend his child's birth but he was in the room when Dr. R walked in to do the delivery. She felt herself bristle as she thought of how Mrs. Hernandez described his earlier behavior. Mr. Hernandez did not change Dr. R's impression as he spent the next few hours laughing inappropriately and making wisecracks while his wife endured her labor pains. He made it especially clear that this baby was to be a boy named after him. No girls' names were even considered. Dr. R was very cool and did not speak to him at all, continuing her supportive relationship with Mrs. Hernandez.

Mr. Hernandez left the room during the last hour of labor. He reentered just as the baby was delivered: a girl. Dr. R continued to address only Mrs. Hernandez and the baby, telling the child "You have such a nice Mommy. She's going to take very good care of you." The next morning on rounds, Dr. R found Mrs. Hernandez somewhat depressed saying her husband had not yet visited, and she knew he wouldn't have left the hospital if the baby had been a boy.

Sometime afterward, Dr. R discussed this experience with a colleague. She wondered how joining questions that helped her reconsider her colleague raised several questions that helped her reconsider her own behavior.

insecurity, and cultural values play in the scenario? In the end, would some alliance between the physician and the father have been helpful to the patient? Dr. R struggled with her own sense of values and her commitment and responsibility to help her patients.

Finally, interactions with colleagues can play a part in how we treat certain patients. Some cases brew controversy. If consultants are drawn into a struggle and become divided over the case, physician difficulty as well as patient resistance can intensify rather than decrease. For example, an oncologist may wish to give a 5-year-old with a malignant brain tumor every possible treatment available even when the side effects of the treatment are severe and the prognosis is not affected. The child's primary care physician in this situation may wish to consider stopping invasive treatments when the child appears certain to die. Because of his longstanding relationship with the family, they look to him for advice about treatment. In intensely emotional situations such as this, struggles between consultants and a primary care physician are common and can mimic the ambivalence the family has over whether to continue treatment.

Family systems consultations and Balint groups offer some of the best solutions to "physician resistance." Family systems consultations can occur when a physician has a systems-oriented colleague who is willing to trade consultations with difficult families. It is rare that another provider does not see a patient or family differently, enabling some new approach to treatment (8). Balint groups are also important vehicles for physicians to examine their own reactions to patients among trusted colleagues (9,10). Every primary care provider needs to have a system for dealing with the inevitable personal issues stimulated by our work. This process allows for the most creative and useful treatment to occur. It also allows challenging patients to facilitate our own growth, personally and professionally.

To conclude this chapter, we present 10 questions to help assess the physician-family alliance. This instrument assesses the likelihood that problems will emerge in the doctor-patient relationship that could impair or negatively influence treatment. Problems in the physician-patient or physician-family alliances can be a function of the patient, the presenting problem, and the approach of the physician. These questions primarily focus on the physician's contribution to building the alliance, clearly only half of the equation, but that half over which one has some control. This instrument will be useful in deciding which families require special attention in developing a therapeutic alliance.

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